Exhibit 19

Patient: Redacted Test Date: 02/13/12

EMG Study

Name		Ins Act.	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
R. Deltoid	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Biceps Brachi.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Ext.Car.R.Ln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Pronator Ter.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Ext.Car.R.Ln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Pronator Ter.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Flx.Car.Uln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Oppon.Pollicis	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Cer Para C5	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Cer Para C6	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Cer Para C7	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Cer Para T1	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Cer Para C4	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Deltoid	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Biceps Brachi.	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Ext.Car.R.Ln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Pronator Ter.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Flx.Car.Uln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Oppon.Pollicis	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Cer Para C5	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Cer Para C6	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Cer Para C7	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Cer Para T1	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Cer Para C4	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Vastus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Tibialis Ant.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Ext.Hal.Ln.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Gastro Med	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Biceps Fem	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Tensor Fas Lt	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Gastroc.Ln.H.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para L2	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para L3	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para L4	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para L5	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para S1	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lum Para S2	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Vastus Lat.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Gluteus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Med Ham	norm	none	none	none	none	norm	norm	norm	norm	norm	
R. Lat Ham	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Vastus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Tibialis Ant.	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Ext.Hal.Ln.	norm	none	none	none	none	norm	norm	norm	norm	norm	

Patient: Redacted Test Date: 02/13/12

L. Gastro Med	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Biceps Fem	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Tensor Fas Lt	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Gastroc.Ln.H.	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Lum Para L2	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Lum Para L3	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Lum Para L4	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Lum Para L5	Normal	Inc	1+	none	none	Inc	norm	norm	norm	norm	norm
L. Lum Para S1	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Lum Para S2	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Vastus Lat.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Gluteus Med.	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Med Ham	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Lat Ham	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Deltoid	norm	none	none	none	none	norm	norm	norm	norm	norm	
L. Biceps Fem	norm	none	none	none	none	norm	norm	norm	norm	norm	

Summary/Interpretation:

1. ABNORMAL EMG STUDY

2. ELECTRODIAGNOSTIC EVIDENCE (EDX) OF LEFT CERVICAL RADICULOPATHY MOST CONSISTENT WITH C5-6 LEVELS

3. NO EDX OF RIGHT CERVICAL RADICULPATHY

4. NO EDX OF BILATERAL RADIAL NEUROPATHY

5. NO EDX OF BILATERAL ULNAR NEUROPATHY

6. NO EDX OF BILATERAL CARPAL TUNNEL SYNDROME

7. NO EDX OF BILATERAL BRACHIAL PLEXOPATHY

8. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O.
JEFF S. PIERCE, D.O.

1. ABNORMAL EMG STUDY

2. ELECTRODIAGNOSTIC EVIDENCE (EDX) SUGGESTIVE OF LEFT LUMBOSACRAL RADICULOPATHY MOST CONSISTENT WITH L4-5 LEVELS

3. NO EDX OF RIGHT LUMBOSACRAL RADICULOPATHY

4. NO EDX OF BILATERAL PERONEAL NEUROPATHY

5. NO EDX OF BILATERAL SURAL NEUROPATHY

Patient: Redacted Test Date: 02/13/12

6. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O.
JEFF S. PIERCE, D.O.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266

CARRIER

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22054X249
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted	3. PATIENT'S BIRTH DATE SEX: Redacted M F X
	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted
	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
	8. PATIENT STATUS: Single Married Other X; Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES NO X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State): MI
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	11. INSURED'S POLICY GROUP OR FECA NUMBER
	a. INSURED'S DATE OF BIRTH MM DD YY SEX: Redacted M F X
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 02 27 12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 10 11 11	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: THOMAS CARUSO DO	17a. 17b. NPI 1144333972
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO X $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 722 0 2. 722 10 3. 723 4 4. 724 4	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 13 12 02 13 12	11		95886		1234	2400 00	4		NPI	1144333972
2 02 13 12 02 13 12	11		95904		1234	2560 00	8		NPI	1144333972
3 02 13 12 02 13 12	11		95900	59	1234	1980 00	6		NPI	1144333972
4 02 13 12 02 13 12	11		95903	59	1234	1830 00	6		NPI	1144333972
5 02 13 12 02 13 12	11		95934	59 RT	1234	385 00	1		NPI	1144333972
6 02 13 12 02 13 12	11		95934	59 LT	1234	385 00	1		NPI	1144333972

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 X	26. PATIENT'S ACCOUNT NO: 40360C31315	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 9540 00	29. AMOUNT PAID $ 0 00	30. BALANCE DUE $ 9540 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): THOMAS CARUSO DO 02 28 12 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: MICHIGAN SPINE & REHAB DT 23861 MCNICHOLS DETROIT MI 48219-3124 a. 1518027606 b.	33. BILLING PROVIDER INFO & PH. # (248) 8894580: MICHIGAN SPINE AND REHAB 2000 TOWN CENTER SUITE 625 SOUTHFIELD MI 48075-1135 a. 1518027606 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

Patient: Redacted 01/11/12 Claim#22051P790

S.S. No.

F-Wave Study

Right Median-Ulnar Nerve

Rec Site:	Latency
Stim Site:	ms
M wave	2.67
F wave	29.50
F-M	26.83

EMG Study

Name						Rep	WC amp	MC amp	MU dur	Phases	Rec Pat	TEXT
R. Deltoid	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Triceps	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Ext.Car.R.L	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Biceps Brac	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Ext.Ind.Pro	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Pronator Te	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Fix.Car.Uln	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Oppon.Polli	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Dors.Int.1	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Abd.Pol.Br.	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Cer Para C5	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Cer Para C6	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Cer Para C7	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Cer Para T1	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Cer Para C4	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
R. Brachioradi	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Deltoid	Normal	inc	none	none	1+	none	norm	norm	norm	norm	full	
L. Biceps Brac	Normal	inc	none	none	1+	none	norm	norm	norm	norm	full	
L. Ext.Car.R.L	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Triceps	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Ext.Ind.Pro	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Pronator Te	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Fix.Car.Uln	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Oppon.Polli	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Dors.Int.1	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Abd.Pol.Br.	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Cer Para C8	Normal	inc	none	none	1+	none	norm	norm	norm	norm	full	
L. Cer Para C5	Normal	inc	none	none	1+	none	norm	norm	norm	norm	full	
L. Cer Para T1	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Cer Para C7	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Cer Para C4	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	
L. Brachioradi	Normal	norm	none	none	none	none	norm	norm	norm	norm	full	

Patient: Redacted 01/11/12 Claim # 72051P790
S.S. No.

Summary/Interpretation:

1. ABNORMAL EMG STUDY

2. ELECTRODIAGNOSTIC EVIDENCE (EDX) SUGGESTIVE OF LEFT CERVICAL RADICULOPATHY MOST CONSISTENT WITH C5-6 LEVELS

3. NO EDX OF RIGHT CERVICAL RADICULOPATHY

4. NO EDX OF BILATERAL RADIAL NEUROPATHY

5. NO EDX OF BILATERAL ULNAR NEUROPATHY

6. NO EDX OF BILATERAL CARPAL TUNNEL SYNDROME

7. NO EDX OF BILATERAL BRACHIAL PLEXOPATHY

8. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O.
JEFF S. PIERCE, D.O.

17ch1216704875

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22051P790

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE MM DD YY: Redacted SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

City

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

ZIP Code

Telephone (Include Area Code)

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: Redacted SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01 23 12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 10 15 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: THOMAS CARUSO DO

17a.

17b. NPI 1144333972

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 722.0
2. 723.4
3. 723.1
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 11 12	01 11 12	11		95886		123	1200 00	2		NPI	1144333972
2 01 11 12	01 11 12	11		95904		123	1920 00	6		NPI	1144333972
3 01 11 12	01 11 12	11		95900	59	123	1320 00	4		NPI	1144333972
4 01 11 12	01 11 12	11		95903	59	123	1220 00	4		NPI	1144333972
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 [X]

26. PATIENT'S ACCOUNT NO.: 39030C28394

27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 5660 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 5660 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

THOMAS CARUSO DO

SIGNED 01 25 12 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MICHIGAN SPINE & REHAB DT
23861 MCNICHOLS
DETROIT MI 48219-3124

1518027606 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580

MICHIGAN SPINE AND REHAB
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-1135

a. 1518027606 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.